PREAUTHORIZATION PROCESS AND DOCUMENTATION REQUIRED

Introduction

Prior authorization (PA) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require PA and some may begin prior to requesting authorization.

Purpose of Prior Authorization

The purpose of prior authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Prior authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Prior authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Prior authorization is performed by DMAS or by a contracted entity.

General Information Regarding Prior Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for PA requests.

The PA entity will approve, pend, reject, or deny all completed PA requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the recipient's right to appeal the denial, in accordance with 42 CFR §200 *et seq* and 12 VAC 30-110 *et seq*. The provider also has the right to appeal adverse decisions to the Department.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care program, the PA entity is able to receive monthly information from and provide monthly information to the Medicaid managed care organizations (MCO) or their subcontractors on services previously authorized. The PA entity will honor the Medicaid MCO prior authorization for services and have system capabilities to accept PAs from the Medicaid MCOs.

Communication

Provider manuals are posted on the DMAS and contractor's websites. The contractor's website outlines the services that require PA, workflow processes, criterion utilized to make decisions, contact names and phone numbers within their organization, information on grievance and

appeal processes and questions and answers to frequently asked questions.

The PA entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the PA process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

SUBMITTING REQUESTS FOR SERVICES

After Medicaid eligibility for the recipient has been established, the contractor will accept requests via direct data entry (DDE), by facsimile, phone, or US Mail. The preferred method is through DDE for a quicker response. The contractor has one business day to process requests from the date the request is received. Specific information regarding the methods of submission may be found at the contractor's website, dmas.kepro.org. The program will take you through the steps needed to receive approval for service requests.

They may also be reached by phone at:

Telephone: 1-888-VAPAUTH
1-888-827-2884

Fax: 1-877OKBYFAX
1-877-652-9329

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. The following chart shows the entity that receives letters generated from MMIS:

	Provider	**Enrolled Individual**	**Comments**
Approval	X	X	
Denial/Partial Denial	X	X	Appeal Rights are included in all denials/partial denials

DMAS will not reimburse providers for dates of service prior to the date(s) identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR). Please see additional requirements in Chapter VI of this manual.

The following documentation is required in order to determine if the individual meets criteria: (1) Certificate of Medical Necessity (CMN), unless items meet exception criteria stated in Chapter IV; (2) Supporting documentation verifying item specific coverage criteria stated in Chapter IV; and (3) Documentation of usual and customary charges or cost as necessary for each HCPCS code used from Appendix B.

All items and supplies must meet the coverage criteria in Chapter IV of this manual and the Virginia Administrative Code. In addition, DMAS requires specific categories of items meet the InterQual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphadema compression devices, manual wheelchairs, negative pressure wound therapy devices, CPAP and BiPAP devices, power wheelchairs and scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with InterQual updates and DMAS discretion.

- The recipient meets InterQual criteria upon admission and continued stay. These criteria may be obtained through:

  McKesson Health Solutions LLC
  275 Grove Street
  Suite 1-110
  Newton, MA 02466-2273
  Telephone: 800-274-8374

  Fax: 617-273-3777
  website: www.mckesson.com or www.InterQual.com

Subsequent Recertification Review

Prior to the end of the last authorized date, the provider should submit the required documents for continued preauthorization. The documentation will be reviewed to determine if it meets DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the physician's signature and date on the certificate of medical necessity. The DMAS preauthorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the preauthorization contractor will authorize a specific number of units and dates of service based on the documentation submitted.

PREAUTHORIZATION PROCESS

The "Medicaid DME Supplies Listing"/Appendix B which is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS), describes equipment and supplies and identifies those which require preauthorization. Preauthorization is required for items identified with a "Y" in the authorization column of the DME Listing/Appendix B, and for any item exceeding the established limits identified in the "limit" column of the DME Listing/Appendix B. **The DME Listing/Appendix B identifies the information above. It does not determine coverage of an item. Coverage criteria are in Chapter IV of the Durable Medical Equipment and Supplies Manual and the Virginia Administrative Code.**

Preauthorization is requested by the enrolled DME provider and not by healthcare professionals involved with the enrollee's care. The provider completes and/or gathers the necessary documentation to meet the Medicaid criteria as described in Chapter IV of this manual.

When extended utilization or unusual amounts of equipment and/or supplies are required, the provider must request preauthorization. If the item does not require preauthorization or does not exceed the established limits, the provider may provide and bill for these items up to the established limit without preauthorization. If preauthorization is required, preauthorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The purpose of preauthorization is to validate that the service or item being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service. Payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Preauthorizations are specific to a recipient, a provider, a service code, an established quantity, and for specific dates of service. (12 VAC 30-50-165)

Effective June 5, 2006 preauthorization for all eligible enrollees, including those in waivers services, will be completed by the preauthorization contractor.

NATIONAL CODES AND RATES

Effective January 1, 2004, providers are required to use national HCPCS codes when billing for DME. Items that do not have a Durable Medical Equipment Regional Carrier (DMERC) rate, with the exception of nutritional supplements, shall be reimbursed the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge. The rates have been incorporated into the Durable Medical Equipment and Supplies Listing/Appendix B of the DME Manual. This listing will be updated periodically. If a national code becomes available for an item, the miscellaneous code can no longer be used for those items. The table below outlines the applicable payment methodology for various DME items.

DME ITEM	RATE
1. DME items that have a national code and a DMERC rate	Rate will be the DMERC rate.
2. DME items that have a July 1, 1996 rate, but do not have a national code	Bill the E1399 code (miscellaneous). The rate will continue to be the July 1, 1996 rate found in the Appendix B.
3. DME items that have a national code, but do not have a DMERC or a July 1, 1996 rate	Rate will be the usual and customary charge to the general public.
4. DME items that do not have a national code, and do not have a July 1, 1996 rate	Bill the E1399 code (miscellaneous). Rate will be the manufacturer's charge to the provider, less shipping and handling, plus 30%

Miscellaneous HCPCS Codes

Use the appropriate HCPCS codes when requesting preauthorization. Miscellaneous codes may only be used when the item requested differs significantly in narrative description from the established HCPCS code. Miscellaneous codes will not be recognized for the sole purpose of

cost variances**.** In order for the preauthorization contractor to determine the appropriate reimbursement for miscellaneous items not in the Appendix B with a fee, all of the following information must be provided:

- A complete description of the item(s) being supplied;
- A copy of the manufacturer's/supplier's invoice or the dealer cost information to document the cost of the item(s);
- For any specially designed items, a statement from the manufacturer detailing cost; and
- Any discount received must be indicated.

The Preauthorization file in VAMMIS combines all like miscellaneous DME codes into one 'rolled up' line, which carries the status of AC (approved combined). Providers see the AC line on their preauthorization notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each of the miscellaneous codes and submit this total or 'rolled up' amount as one line item on the claim.

For items identified in number 4 above: A mark-up of 30 percent of the actual cost (less any discounts available to the DME provider), as determined by the preauthorization contractor. If the provider receives a manufacturer/supplier discount and cost plus 30% mark-up equates to greater than the manufacturer's suggested retail price (MSRP), then reimbursement will be the MSRP. If the cost plus 30% mark-up equates to greater than the amount requested in box 24 of the DMAS-351 R then the amount requested in box 24 will be authorized. The reimbursement will be based on the provider description of the item(s) or supplies. Box 25 on the DMAS-351 R must include a description of the miscellaneous item requested. This description must be identifiable on the price sheet and on the medical documentation attached. Request for multiple E1399 items received with no description in box 25 will rejected. Adequate and complete descriptions, quantities, and the unit price are essential for the evaluation of the charge. Wherever possible, use the appropriate HCPCS codes.

On Quality Management Review, the actual cost of the item will be compared to the estimated costs provided for preauthorization. If the actual cost is less than reported on preauthorization, the provider must adjust their billed amount to reflect the actual cost.

PRIOR AUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

Provider Appeals

If services are denied by the preauthorization analyst an automatic reconsideration process will be conducted by a physician reviewer and the provider will be notified of the outcome of the decision.

After completion of the reconsideration process, the denial of pre-authorization for services not yet rendered may be appealed in writing by the Medicaid client by sending a written request for an appeal within 30 days of the receipt of the notice of denial. The client or the client's authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488. If the preauthorization denial is for a service that has already been rendered, the provider may appeal

the adverse decision by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the denial. The notice is considered filed when it is date stamped by the Appeals Division. The notice must identify the issues being appealed and must be sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th floor
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

If the denied intensive rehabilitation service has not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter VI of this manual.

Early Periodic Screening Diagnosis and Treatment

Prior Authorization

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the recipient.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently preauthorized by the PA contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific

item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.org. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all pre authorization reviews of prior authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver recipients may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT review process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current treatment modalities.

The review process as described is to be applied across all non waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been

submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).